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Indiana Commission on
Health Care Interpreters and Translators

REPORT

Finding and Recommendations

Translation Interpretation Communication

October 2004

Indiana Commission on Health Care Interpreters and Translators

Report:

Findings and Recommendations

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Executive Summary

The Commission on Health Care Interpreters and Translators would like to acknowledge the long-term process that the state has embarked on, and urge legislators, non-profit organizations, health care providers and all interested parties to follow the process that other states have developed in their quest to implement state certification in health care interpreting. Their years of experience have proven that this is a sequential process that requires careful planning and specific expertise in order to accomplish quality and equal access to health care. The use of professionally qualified and certified health care interpreters and translators addresses the health care barriers faced by non-English proficient, limited English proficient and deaf and hard of hearing patients.

This report outlines an approach to develop a state certification program for health care interpreters by delineating incremental steps that follow a sequential process. It also includes some recommended guidelines for the use of qualified health care translators, as national certification for translators and American Sign Language interpreters currently exist. The goal of the incremental steps is to meet the immediate needs for pools of qualified health care interpreters and translators through the establishment of a workable time frame. This time frame allows practicing health care interpreters and translators to pass an initial assessment to receive the status of "qualified health care interpreter" until certification is implemented, and the status of "qualified health care translator" for those who do not seek national certification. This would provide the state of Indiana with a registry of qualified professionals, time to offer training and professional development opportunities, and move towards success when statewide certification is implemented.

The Commission makes the following recommendations given in summary format. More detailed information under each recommendation may be found in the body of the report.

1. The legislature should reauthorize the Commission to continue until the scope of its work is complete and until a permanent body is established to regulate certification. The Commission will partner with related commissions, councils and professional organizations in order to complete its scope of work. Drawing upon the expertise of other states that have been working on certification, the Commission recommends that its first goal be to write a five-year strategic plan for a certification program for health care interpreters and qualified health care translators in the state of Indiana. This plan will be used to operate and implement the recommendations of this report.

2. The Commission recommends developing an identity system in order to allow buy-in from those currently associated in the health care field, present and future health care interpreters and translators, to health care providers, patient advocacy groups, and educators. The Commission also recommends establishing a web site to post developments in the process of certification as well as a listserv where interested parties may offer comments on access to the certification process. To accomplish this, the Commission recommends funding be appropriated to establish and maintain the web site and listserv.

3. The Commission recommends appropriate levels of financial and human resources in order to accomplish the goals of the Commission to improve access to quality health care. The sequential process that is required to implement a certification program needs to be reflected in a revised fiscal impact statement. Implementation in incremental stages is outlined below. Funding will be needed

through each stage to accomplish the goals for development and implementation of a certification program which will be carried out in the most economical and timely framework. This program will establish interpreter standards and serve as a model for professional standards of practice throughout the state.

4. The Commission recommends that the Standards of Practice and Code of Ethics proposed in this document be adopted immediately and that they be disseminated to practicing health care interpreters, health care translators as well as to health care providers. It further recommends that the Commission review the National Council on Interpreting in Health Care National Standards of Practice which is projected to be complete in 2005, to make a recommendation to adopt these National Standards as well as the currently existing National Code of Ethics.

5. The Commission recommends establishing a Committee on Health Care Interpreter Qualifications to carry out an initial assessment of qualifications to define an interim fundamental standard for health care interpreting. National certification for American Sign Language interpreters is available, but the Committee will also define a fundamental standard for qualifications in American Sign Language health care interpreting. This would require additional training in health care terminology and health care systems for certified American Sign Language interpreters. Completion of this task would allow the state to offer qualified health care interpreter status within a year of legislative approval and funding appropriated for this task.

6. The Commission recommends establishing a Committee on Health Care Translator Qualifications to carry out an initial assessment of qualifications to define an interim fundamental standard for health care translators. At the state level, the status of qualified translator will remain permanent, recognizing that national certification for translators is available and should be encouraged to acknowledge an advanced level of qualification for those achieving national certification. Completion of this task would allow the state to offer qualified health care translator status within a year of legislative approval and funding appropriated for this task.

7. The Commission recommends establishing a Committee on Education and Training to research current education and training in the fields of health care interpreting and translation. This Committee will make recommendations and survey partnering possibilities in order to provide education and/or training opportunities. The Committee will gather information about additional professional development opportunities and assure a continued assessment mechanism for renewal of interim qualified health care interpreter status until health care interpreter certification and qualified health care translator status is implemented. This body will also set training requirements for health care interpreters and translators as well as continuing education or training requirements to renew qualified status or certification.

8. The Commission recommends establishing a Committee on Assessment that will be responsible for surveying current assessment tools that could be adopted for the state of Indiana, or to pursue the possibility of writing, piloting and validating a certification assessment tool that would reflect the needs of the populations served in Indiana. In lieu of being able to adopt any current assessment tools, the Commission recommends funds be appropriated for the development of an assessment tool for state certification of health care interpreters, and an assessment tool for qualified translators.

9. The Commission recommends that the Committees as set forth in numbers 5, 6, 7 and 8 above be established as subcommittees of the Commission comprised of both Commission members and other subject matter experts as deemed necessary.

10. The Commission recommends the appointment of a representative from a professional interpreting association serving deaf and hard of hearing persons or the Deaf and Hard of Hearing Services Board of Interpreter Standards to the Commission.

11. The Commission recommends as staggered appointments are made, there is an effort to appoint members who have the time to contribute to completing the goals of the Commission.

12. The Commission recommends that the Commission for Health Care Interpreters and Translators continue in existence until a permanent body is formed that will serve as the regulatory oversight for certification. This body will authorize the administrative body that awards certification for health care interpreters and recognize qualified health care translators.

This report with the recommended incremental implementation envisages a collaborative effort of all committees monitored by the Commission for Health Care Interpreters and Translators until a regulatory body is established.

The ultimate goal of this report is to facilitate legislators, health care organizations, the regulatory body and its administrative units to offer recommendations on the most efficient and appropriate sequential path to establish standards of health care interpreting and translation that are closely tied to standards set at the national level.

Introduction

Title VI of the Civil Rights Act of 1964 provides that no person shall on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. On August 11, 2000, Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," ordered that every federal agency which provides financial assistance to non-federal entities must publish guidance on how their recipients can provide meaningful access to limited English proficient (**LEP**) persons and thus comply with Title VI regulations. This Executive Order charged the Department of Justice with the responsibility of providing **LEP** guidance to other federal agencies. Consistent with Executive Order 13166, the U.S. Department of Health and Human Services (**HHS**) Office for Civil Rights (**OCR**) developed its 2000 "Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency" (**HHS** Guidance). **HHS** revised its **LEP** Guidance in 2002; it delineates methods for compliance that **LEP** individuals have language assistance to access health care. Within this Guidance, **HHS** outlines the need for use of competent interpreters and translators and specifically points out that "self-identification as bilingual" is not an acceptable measurement for carrying out the complex tasks of interpreting and translating. The **HHS** Guidance included further recommendations about hiring qualified interpreters and translators, the use of telephonic interpreting, and noted the complications and ethical implications of using minors and family members.

In spite of this Guidance, health care organizations hire and use inadequately trained interpreters and translators. The scarcity of educational and/or training programs leads to an increase of inadequate patient care, misdiagnosis, and diminished access to health care for patients who fear that they will not be able to communicate with the health care provider for lack of an interpreter. Furthermore, translated materials may be poorly translated, causing misunderstanding of health care provider instructions. Texts to be translated may not have been adapted for a person with a low level of education and in many cases translated documents must be read by a bilingual individual to someone who cannot read in any language.

The requirement to provide meaningful access to **LEP** persons is enforced and implemented by the **HHS** Office for Civil Rights through procedures identified in the Title VI regulations. National and state professional organizations, which through education and training, dissemination of materials, and outreach programs, assist health care providers in complying with their obligations. Indiana has made significant progress in complying with the **HHS** Guidance.

As the number of diverse populations increases in Indiana, there is an ever increasing need for competent health care interpreters and translators to provide access to health care. It is based on this premise that House Enrolled Act No. 1350 (P.L. 61-2004) was passed and signed by Governor Joseph E. Kernan in March 2004. P.L. 61-2004 establishes a Commission with these specific charges:
(1) Write Bylaws concerning the operation of the Commission.
(2) Define the terms "health care interpreter" and "health care translator."
(3) Review and determine the proper level of regulation or oversight that Indiana should have over health care interpreters and translators practicing in Indiana.

(4) Recommend the level and type of education necessary to perform the job of
    (A) A health [care] interpreter; and
    (B) A health care translator.
(5) Recommend standards that health care interpreters and health care translators should meet in order to practice in Indiana.

House Enrolled Act No. 1350 (P.L. 61-2004) is in Appendix A.

Members of the Commission on Health Care Interpreters and Translators
P.L. 61-2004 states that the state health commissioner shall appoint the members of the commission in a manner to maintain cultural and language diversity. Furthermore, the state health commissioner shall designate the chairperson and the vice chairperson of the commission. Based on a list of nominations submitted to State Health Commissioner Gregory A. Wilson, M.D., he appointed the following members:

Enrica J. Ardemagni, Ph.D., Chair, Indiana University Purdue University Indianapolis
Carolin Requiz, M.A., Vice-Chair, Member, Interagency Council on Black and Minority Health
Deepak Azad, M.D., Indiana State Medical Association
Enrico Garcia, M.D., Health Officer, Vigo County Health Department
Saby Guidicelli, St. Vincent Hospital
Connie Floerchinger, MS, MHA, Advantage Health Solutions, Inc.[sm]
Lisa Hayes, J.D., Indiana Health Professions Bureau
Randy Koester, J.D., Indiana Department of Corrections
José Lusende, Member, Midwest Association of Translators and Interpreters
Monica Medina, M.Ed., Indiana State Department of Health
Kathy Moses, MPH, Office of Medicaid Policy and Planning
Amelia Muñoz, MSW, Indiana Latino Institute
Brian Shockney, MHA, Logansport Memorial Hospital
Hilda Vazquez, Indiana Department of Education
William Zart, M.A., Indy Translations, LLC

Ad hoc Members of the Commission
The bylaws of the Commission state that the Chair shall be able to appoint ad hoc members to the Commission as he or she deems necessary. Chair Enrica J. Ardemagni appointed the following members:

James Van Manen, M.A., RID, CI and CT, Deputy Director, Indiana Deaf and Hard of Hearing Services
Marta Rainero, M.A. in English and Spanish Translation

Acknowledgements

The Commission members would like to thank the following individuals who facilitated the work of the Commission and those who offered their expertise in the preparation of this final report.

Gregory A. Wilson, M.D., State Health Commissioner, Indiana State Department of Health
Representative John Aguilera, 12th House District, East Chicago, IN
Zach Cattell, Legislative Affairs, Indiana State Department of Health
Tanya Williams, Public Health Administrator, Office of Minority Health, Indiana State Department of Health
Wilma Alvarado-Little, MA, Co-Chair of the Board, The National Council on Interpreting in Health Care
Joy Connell, Co-Chair, Organizational Development Committee, The National Council on Interpreting in Health Care; Massachusetts Medical Interpreters Association
Esther Diaz, Co-Chair of the Organizational Development Committee, The National Council on Interpreting in Health Care; Austin Area Translators and Interpreters Association
Stanley W. DeKemper, President, Unlimited Synergy
Stephanie DeKemper, President, Centene Foundation for Health Care
Disa Jernudd, M.A., Diversity Development Consultant
Nancy Jewell, President and CEO, Indiana Minority Health Coalition
David Geeslin, Deaf and Hard of Hearing Services, Board of Interpreter Standards
Charles A. Hiltunen, III, The Third House Advocacy Group
Maria Michalczyk, RN, MA, Co-Chair of the Board, The National Council on Interpreting in Health Care, Chair for the Governor's Council on Health Care Interpreting in Oregon.
Hongbich Holly Thomas, Language Specialist – Vietnamese, Professionally Certified, State and Federal Qualified
Carol Paddock, Sigma Theta Tau, International Honor Society of Nursing
Cynthia Roat, Chair of the Advisory Committee, The National Council on Interpreting in Health Care
Anthony Zapata, Esq., Indiana Supreme Court
Michael McClain, Office of Minority Health, Indiana State Department of Health
Martha Roots, Acting Secretary of the Commission, Legislative Affairs, Indiana State Department of Health
Jill Russell, J.D., Office of Legal Affairs, Indiana State Department of Health
Montserrat Zuckerman, BSN, Translations InterAmerica, Inc., Secretary, Midwest Association of Translators and Interpreters

Methodology

P.L. 61-2004 established five charges for the Commission. The first charge, (1) to write Bylaws concerning the operation of the Commission, was facilitated by Jill Russell from the Office of Legal Affairs at the Indiana State Department of Health (**ISDH**). The full Bylaws may be found in Appendix B. This allowed the Commission members to focus on the four other charges which are:
(2) Define the terms "health care interpreter" and "heath care translator."
(3) Review and determine the proper level of regulation or oversight that Indiana should have over health care interpreters and health care translators practicing in Indiana.
(4) Recommend the level and type of education necessary to perform the job of:
    (A) A health [care] interpreter; and
    (B) A health care translator.
(5) Recommend standards that health care interpreters and health care translators should meet in order to practice in Indiana.

The Commission members accomplished these tasks by working in subcommittees that matched their areas of expertise. The Commission Chair appointed two ad hoc members, James Van Manen, to represent the deaf and hard of hearing community, and Marta Rainero, to add more expertise in the areas of translation and interpreting. One Commission member, Holly Nguyen-Thomas, resigned in August and Commissioner Gregory A. Wilson appointed William Zart of IndyTranslations, LLC to fill her position. The subcommittee members are listed below:

Subcommittee on Terms and Definitions: José Lusende, Chair; Enrica J. Ardemagni; Monica Medina; Holly Nguyen-Thomas; James Van Manen; Hilda Vazquez
Subcommittee on Standards of Practice: Connie Floerchinger, Co-Chair; Amelia Muñoz, Co-Chair; Dr. Deepak Azad; Randy Koester; José Lusende; James Van Manen.
Subcommittee on Qualifications and Training: Hilda Vazquez, Chair; Enrica J. Ardemagni; Saby Guidicelli; Holly Nguyen-Thomas; Monica Medina; James Van Manen.
Subcommittee on Regulatory Oversight: Carolin Requiz, Chair; Lisa Hayes; Kathy Moses; Brian Shockney; James Van Manen.

As can be seen by the Table of Contents of this report, the Commission has restructured the charges as they appear in HEA No. 1350 (P.L. 61-2004) in the findings and recommendations. The purpose for restructuring the charges is to highlight the importance of following the sequential process this report outlines towards certification and its implementation. It illustrates the flow of both the necessary steps that need to be taken towards certification as well as areas in which the funding will need to be appropriated to support each component of the certification process.

This final report, *Indiana Commission on Health Care Interpreters and Translators Report: Findings and Recommendations,* was written with the collaborative effort of the Commission's members. It was reviewed and approved by the Commission on October 21, 2004.

Terms and Definitions

P.L. 61-2004 stipulates that the Commission will define the terms "health care translator" and "health care interpreter." These specific definitions as well as clarification on modes of interpreting and specifics on translation are included in this section. Furthermore, this report uses specific terminology to refer to the emerging fields of health care interpreting and translation, and the Commission members voted to include a glossary that defines the most commonly used terms in these fields. The definitions were collected from various sources and are listed in Appendix C with an abbreviated reference for the source of each definition. The full citations for these references are found in Appendix G.

Certified interpreter: A professional interpreter who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. Interpreters who have had limited training or have taken a screening test administered by an employing health care, interpreter or referral agency are not considered certified. (**CHIA**)

Certified translator: A professional translator who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria.

Community interpreting: Interpreting that takes place in the course of communication in the local community among speakers of different languages. The community interpreter may or may not be a trained interpreter. Compare to health care interpreting in medical settings or education interpreting in school settings. (**NCIHC**)

Community/Liaison interpreting: Interpreting that takes place in the local community among speakers of different languages. (Adapted from **NCIHC**)

Consecutive interpreting: A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce the message after the speaker or signer pauses, in a specific social context. (**ASTM**) See **simultaneous interpreting.**

Health care interpreter: A professional interpreter who works primarily in the field of health care facilitating the oral or visual/spatial communication between the provider and the patient and his or her family. (Adapted from **NCIHC**)

Health care interpreting/translating: Interpreting/translating that takes place in health care settings of any sort, including but not limited to doctor's offices, clinics, hospices, hospitals, home health visits, mental and health clinics. (Adapted from **NCIHC**)

Health care translator: A professional who specializes in the translation of written medical documents from one written language into another. (Adapted from **NCIHC**)

Interpreter: A person who facilitates communication between two or more users of different oral or visual/spatial languages. (Adapted from **NCIHC**)

Interpreting: (1) Noun: Referred to as Interpretation, the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account. (**ASTM**)
(2) Adjective: Concerning or involved with interpreting. (**NCIHC**)

Interpretation: While interpreting and interpretation have the same meaning in the context of oral/signed communication, the term interpreting is preferred because it emphasizes process rather than product, and because the word interpretation has many uses outside the field of translation and interpreting. (**NCHIC**)

Professional interpreter: An individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to a code of professional ethics. (**NCIHC**)

Professional translator: An individual with appropriate training and experience who is able to translate with consistency and accuracy and who adheres to a code of professional ethics. (Adapted from **NCIHC**)

Simultaneous interpreting: A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce in real time a speaker or signer's message while the speaker or signer continues to speak or sign in a specific social context. (**ASTM**) See **consecutive interpreting**.

Translation: The conversion of a written text from one language into a corresponding written text in a different language. In the language professions, the translation is distinguished from interpretation as the former refers to the message produced in writing and the latter refers to the message produced orally or visually/spatially. (Adapted from **NCIHC**)

Translating: See **translation**.

Translator: A person who translates written texts, especially one who does so professionally. (**NCIHC**) See **translation, interpreter**.

Standards of Practice and Code of Ethics

P.L. 61-2004 charge number (5), now in order as the first and most important component in the sequential process of certification, requires the Commission to recommend standards that health care interpreters and health care translators should meet in order to practice in Indiana. The rules of conduct from many organizations were reviewed and assessed for applicability, appropriateness and ease of understanding. After several discussions and review of the National Council on Interpreting in Health Care's (**NCIHC**) document "Standards of Practice for Interpreters: An Environmental Scan," the Commission determined that many organizations have standards of practice and/or codes of ethics. The environmental scan concludes that there is much overlap between standards of practice and codes of ethics. The **NCIHC** report also concludes that:

- Standards of practice tend to be more detailed than codes of ethics.
- Standards of practice are often intended to illustrate practical ways to enact a code of ethics.

For the reasons listed above the Commission has determined that a standard of practice is applicable to health care interpreters and translations as well as to the organization or entity that hires an interpreter or translator. The standards would be included in the orientation process for the organization and would be specific to that organization. The Commission recommends the adoption of the **NCIHC** National Health Care Standards of Practice when they are completed, which is projected to be in 2005. In the interim, the Commission recommends the Standards of Practice found in this report. Components in a code of ethics for health care interpreters and translators should include statements addressing the following:

***Confidentiality**	***Non-Judgmental Attitude**	***Compensation**
***Accuracy**	***Client Self-Determination**	***Self-Evaluation**
***Completeness**	***Attitude Toward Clients**	***Ethical Violations**
***Conveying Cultural Frameworks**	***Acceptance of Assignments**	***Professionalism**

After reviewing several codes of ethics documents, it was decided that the National Code of Ethics established by the National Council on Interpreting in Health Care and the Professional Conduct issued by the Registry of Interpreters of the Deaf (**RID**) and Business Practices document from the American Translators Association (**ATA**) could be adapted and made into a code of ethics for health care interpreters and translators in the state of Indiana. While these codes are the current gold standard for interpreting and translating, the National Code of Ethics established by the **NCIHC** is the only one particular to the field of health care today. Two include the same elements as the code of ethics from RID, as well as the *Bridging the Gap* interpreter training program.

Bridging the Gap is a 40-hour basic/intermediate health care interpreter training course that includes:

- Instruction in basic interpreting skills (role, ethics, conduit and clarifier interpreting, intervening, managing the flow of the session).

- Information about health care (introduction to the health care system, how doctors think, anatomy, basic medical procedures).
- Introduces awareness of culture in interpreting (self-awareness, basic characteristics of specific cultures, traditional health care in specific communities, culture-brokering).
- Gives an introduction to communication skills for advocacy (listening skills, communication styles, appropriate advocacy).
- Provides guidance for professional development.

There is a certain amount of legitimacy to adopting the **NCIHC** National Code of Ethics. The Department of Health and Human Services Office of Minority Health has contracted with the **NCIHC** to develop consensus around a single nationally accepted Code of Ethics for Interpreters in Health Care. Below is the proposed Indiana code of ethics for health care interpreters and translators that combine elements from the codes of the **NCIHC,** the **RID** and the **ATA**. The elements have been combined from the above programs to create the hybrid code of ethics the Commission proposing.

Confidentiality

The interpreter or translator shall treat as confidential all information learned in the performance of his/her professional duties. All information will be safeguarded in the interest of the client. No confidential information will be divulged unless otherwise required by state law. Confidentiality shall be maintained in compliance with the Health Insurance Portability and Accountability Act and in all situations except when the state mandates the disclosure of information in specific situations. That interpreters will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable and imminent harm to self or other identifiable persons (**AMA**).

> (a) Except as stated in paragraph (b), health care interpreters or translators must keep all information learned during the interpretation/translation assignment confidential, revealing nothing without the consent of the patient and the patient's health care provider.
> (b) A health care interpreter or translator may reveal such information to the extent the interpreter or translator believes necessary:
>
> > (1) To defend any claim made by the patient against the health care interpreter/translator, or health care provider; or
> > (2) To comply with applicable laws which abrogate the privileged communication.

Accuracy and Completeness

The interpreter or translator shall render the message or information faithfully, conveying the content and spirit of the original message while taking into consideration its cultural context. Mastery of the source and target languages must be equivalent to that of an educated native speaker and the interpreter or translator should endeavor to interpret or translate the original message faithfully, to satisfy the needs of the end user(s).

This means that interpreters shall interpret everything the speaker says without changing the meaning, conveying what is said and how it is said without additions, deletions or alterations, but

with due consideration of the cultural context of both the sender and the receiver of the message. The interpreter must convey the meaning of gestures, body language, and tone of voice. Additionally, interpreters and translators must reveal and correct any errors they have made in carrying out their professional duties. The translator must carry out the proper translating procedures to ensure that content of the original information is maintained.

Impartiality
The interpreter or translator shall maintain impartiality and shall not counsel, give advice or project personal biases or beliefs.

Interpreters and translators must remain impartial by suspending judgment and making no personal comment, verbal or non-verbal, on the content of the communication. Interpreters must avoid distorting the message in favor of one party or the other. Under no circumstances should interpreters give advice to patients.

Professional Boundaries
The interpreter shall maintain the boundaries of the professional role, refraining from personal involvement.

Interpreters shall avoid getting personally involved with the people for whom they interpret. This does not mean that interpreters cannot be friendly and caring. The development of rapport with patients and providers during a pre-session is a part of the interpreter's professional role and does not necessarily represent personal involvement.

Professional Development
Interpreters and translators shall strive to continually further their knowledge and skills.

Interpreters and translators shall engage in ongoing professional development activities. Interpreters and translators shall improve upon their linguistic knowledge and maintain their interpreting or translating skills by reading current literature and taking advantage of educational opportunities such as workshops, trainings, etc. They shall also continue to expand their knowledge of the medical contexts in which they may be called to function and of the socio-cultural contexts, including folk medicine and illnesses of the patient populations for whom they interpret or translate. Interpreters and translators shall maintain up-to-date knowledge of the subject matter and its terminology in both languages.

Interpreters and translators shall gain access to information resources and reference materials, and build upon their knowledge of the tools of the profession.

Cultural Competence
The interpreter or translator shall develop awareness of his/her own and other cultures in order to promote cross-cultural understanding.

Interpreters and translators shall strive to bridge the cultural differences between all participating parties by seeking to minimize, and if possible avoid, potential misunderstandings based upon stereotyping and/or differing cultural practices, beliefs or expectations. Under certain conditions such as clashing cultural beliefs or practices, a lack of linguistic equivalency, or the inability of parties to articulate in their own words, the interpreter or translator shall assist (with the explicit

consent of all parties to this intervention) by sharing cultural information or helping develop an explanation that can be understood by all.

Respect for all Parties
The interpreter or translator shall strive to support mutually respectful interactions among all parties.

Interpreters can help build mutual respect within the triadic relationship by responding in a supportive manner within the interpreter role, using rapport-building skills, respecting the experience or expertise of all parties, allowing physical privacy to the patient, refraining from influencing patient decisions, and treating all participating parties equally and with dignity.

Professional Integrity
The interpreter or translator shall demonstrate professionalism and personal integrity. The following are aspects of professionalism:

- If the interpreter or translator believes at any time that s/he may have interpreted or translated inaccurately or incompletely, s/he will make this known and, if possible, provide a corrected interpretation or translation.
- Translators will use a client as a reference only if s/he is prepared to name a person to attest to the quality of his/her work.
- Interpreters and translators will respect and refrain from interfering with or supplanting any business relationship between his/her client and his/her client's client.
- An interpreter or translator shall not accept an assignment, or shall withdraw from an assignment for which s/he 1) is not competent to interpret accurately and completely, 2) perceives a conflict of interest between his/her role as interpreter and his/her personal involvement with one of the parties in the interpretation, 3) is so impacted by the content to be interpreted that s/he become unable to interpret accurately and completely, and 4) will notify his/her clients of any unresolved difficulties. Arbitration shall be the means of resolving any disputes.
- The fee agreed to between the interpreter or translator and the contracting/employing agency shall be the only compensation the interpreter or translator will accept. The interpreter or translator will not accept additional compensation or considerations from any party in the interpreted session.

National Standards for Culturally and Linguistically Appropriate Services in Health Care: Existing Federal Standards

The following national standards issued by the U.S. Department of Health and Human Services (**HHS**) Office of Minority Health (**OMH**) respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (**CLAS**) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic,

and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The **CLAS** standards are primarily directed to health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

- **CLAS** mandates are current federal requirements for all recipients of federal funds (Standards 4, 5, 6, and 7).
- **CLAS** guidelines are activities recommended by **OMH** for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- **CLAS** recommendations are suggested by **OMH** for voluntary adoption by health care organizations (Standard 14).

For the purposes of this commission the focus will be on the four mandated standards which are the Language Access Services. All 14 standards are attached in Appendix D.

The standards are intended for use by:

- Policymakers, to draft consistent and comprehensive laws, regulations, and contract language. This audience would include Federal, State and local legislators, administrative and oversight staff, and program managers.
- Accreditation and credentialing agencies, to assess and compare providers who say they offer culturally competent services and to assure quality for diverse populations. This audience would include the Joint Commission on Accreditation of Healthcare Organizations (**JCAHO**), the National Committee for Quality Assurance (**NCQA**), professional organizations such as the American Medical Association (**AMA**) and American Nurses Association, and quality review organizations such as peer review organizations.
- Purchasers, to advocate for the needs of ethnic consumers of health benefits and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.
- Patients, to understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them.
- Advocates, to promote quality health care for diverse populations and to assess and monitor care being delivered by providers. The potential audience is wide, including legal services and consumer education protection agencies; local and national ethnic, immigrant, and other

community-focused organizations; and local and national nonprofit organizations that address health care issues.

- Educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include educators from health care professions and training institutions, as well as educators from legal and social services professions.

- The health care community in general, to debate and assess the applicability and adoption of culturally and linguistically appropriate health services into standard health care practice.

Language Access Services (Standards 4, 5, 6, and 7)

CLAS Standard 4: Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation.

Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (**LEP**) individuals. Title VI requires all entities receiving Federal financial assistance, including health care organizations, take steps to ensure that **LEP** persons have meaningful access to the health services that they provide. The key to providing meaningful access for **LEP** persons is to ensure effective communication between the entity and the **LEP** person. For complete details on compliance with these requirements, consult the HHS guidance on Title VI with respect to services for (**LEP**) individuals (65 FR 52762-52774, August 30, 2000) at www.hhs.gov/ocr/lep.

Language services, as described below, must be made available to each individual with limited English proficiency who seeks services, regardless of the size of the individual's language group in that community. Such an individual cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or nonclinical staff at a health care organization. (Patients needing services in American Sign Language would also be covered by this standard, although other Federal laws and regulations apply and should be consulted separately.)

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language. The competence and qualifications of individuals providing language services are discussed in Standard 6.

CLAS Standard 5: Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services.

LEP individuals should be informed--in a language they can understand--that they have the right to free language services and that such services are readily available. At all points of contact, health

care organizations should also distribute written notices with this information and post translated signage. Health care organizations should explicitly inquire about the preferred language of each patient/consumer and record this information in all records. The preferred language of each patient/consumer is the language in which he or she feels most comfortable in a clinical or nonclinical encounter.

Some successful methods of informing patients/consumers about language assistance services include: (a) using language identification or "I speak * * *" cards; (b) posting and maintaining signs in regularly encountered languages at all points of entry; (c) creating uniform procedures for timely and effective telephone communication between staff and LEP persons; and (d) including statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

CLAS Standard 6: Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/Consumer).

Accurate and effective communication between patients/consumers and clinicians is the most essential component of the health care encounter. Patients/consumers cannot fully utilize or negotiate other important services if they cannot communicate with the non-clinical staff of health care organizations. When language barriers exist, relying on staff that are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual person for delivering language services they must assess and ensure the training and competency of individuals who deliver such services.

Bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter. Ideally, this should be verified by formal testing. Research has shown that individuals with exposure to a second language, even those raised in bilingual homes, frequently overestimate their ability to communicate in that language, and make errors that could affect complete and accurate communication and comprehension.

Prospective and working interpreters must demonstrate a similar level of bilingual proficiency. Health care organizations should verify the completion of, or arrange for, formal training in the techniques, ethics, and cross-cultural issues related to medical interpreting (a minimum of 40 hours is recommended by the National Council on Interpretation in Health Care). Interpreters must be assessed for their ability to convey information accurately in both languages before they are allowed to interpret in a health care setting.

In order to ensure complete, accurate, impartial, and confidential communication, family, friends or other individuals, should not be required, suggested, or used as interpreters. However, a patient/ consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the **LEP** person's confidentiality is violated. The health care organization's staff should suggest that a

trained interpreter be present during the encounter to ensure accurate interpretation and should document the offer and declination in the **LEP** person's file. Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the patients/consumers.

CLAS Standard 7: Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area.

An effective language assistance program ensures that written materials routinely provided in English to applicants, patients/consumers, and the public are available in commonly encountered languages other than English. It is important to translate materials that are essential to patients/consumers accessing and making educated decisions about health care. Examples of relevant patient-related materials include applications, consent forms, and medical or treatment instructions; however, health care organizations should consult OCR guidance on Title VI for more information on what the Office considers to be "vital" documents that are particularly important to ensure translation (5 FR 52762-52774, August 30, 2000 (www.hhs.gov/ocr/lep).

Commonly encountered languages are languages that are used by a significant number or percentage of the population in the service area. Consult the **OCR** guidance for guidelines regarding the **LEP** language groups for which translated written materials should be provided. Persons in language groups that do not fall within these guidelines should be notified of their right to receive oral translation of written material.

Signage in commonly encountered languages should provide notices of a variety of patient rights, the availability of conflict and grievance resolution processes, and directions to facility services. Way-finding signage should identify or label the location of specific services (e.g., admissions, pediatrics, emergency room). Written notices about patient/consumer rights to receive language assistance services are discussed in Standard 5.

Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of patients/consumers. Organizations should provide notice of the availability of oral translation of written materials to **LEP** individuals who cannot read or who speak non-written languages. Materials in alternative formats should be developed for these individuals as well as for people with sensory, developmental, and/or cognitive impairments.

The obligation to provide meaningful access is not limited to written translations. Oral communication often is a necessary part of the exchange of information, and written materials should never be used as substitutes for oral interpreters. A health care organization that limits its language services to the provision of written materials may not be allowing **LEP** persons equal access to programs and services available to persons who speak English.

Organizations should develop policies and procedures to ensure development of quality non-English signage and patient-related materials that are appropriate for their target audiences. At a minimum, the translation process should include translation by a trained individual, back translation and/or review by target audience groups, and periodic updates.

It is important to note that in some circumstances verbatim translation may not accurately or appropriately convey the substance of what is contained in materials written in English.

Additionally, health care organizations should be aware of and comply with existing State or local nondiscrimination laws that are not superseded by Federal requirements.

The complete report, along with supporting material, is available online www.hhs.gov/ocr/lep.

Best Practices in CLAS Implementation

The Cross Cultural Health Care Program (**CCHCP**) surveyed health care programs to determine best practices in the implementation of the **CLAS** standards in a report that was completed in 2003. The survey portrays how the **CLAS** Language Access Standards were implemented by sites that represent best practices in CLAS implementation.

1. Lowell Community Health Center (LCHC), Lowell, Massachusetts. Motto - "Linking Community to Health Care."

History/Demographics/Patients Served in Lowell (population 105,000)
- 8th highest teen pregnancy rate in the state
- >28% of Lowell's children live below the poverty level
- Latinos are 3 times more likely to have asthma than the rest of the population
- > 50% of Cambodians experience moderate/severe mental health problems vs. 15% of the general death rate due to alcohol and other drug use 39/100,000 vs. 14.2 statewide
- AIDS death rate 33.3 versus 14.2 statewide

LCHC is a Federally Qualified Community Health Center which serves 20,000 patients annually. LCHC cares for a number of high-risk populations: 15% of the Lowell community is Latino, a population heavily impacted by asthma, and this community comprises 37% of the LCHC clientele. More than 28% of Lowell's children live below national poverty guidelines (vs. 12.9% statewide).

Language Access - Bilingual Staff Model
LCHC uses a bilingual staff model for interpretation needs. The majority of LCHC's bilingual staff has been trained in medical interpreting; staffing in clinic sites is designed so that languages like Portuguese are covered throughout the system. Blue Cross Blue Shield Foundation funds training and LCHC provides incentives for language skills and training. Workers have dual roles in the clinics and many are purposely cross-trained. In area after area, language needs have necessitated shared work roles and have become a staff expectation as well as a source of excitement and pride. An internal course is being developed to train providers to work effectively with LEP patients and interpreters. Beyond training interpreters, LCHC has instituted language training at multiple levels. Staff trainings to introduce or to upgrade language skills are also available.

Assessment and upgrading of signage **(CLAS** Standard 7**)** at each site is part of Lowell's annual cycle of self-assessment. Current signage is in the four commonly used languages at LCHC: English, Spanish, Portuguese and Khmer. Plans are underway to incorporate African languages that are entering the clinic.

CLAS Standards 4-6: Language Services
At LCHC, staffing is such that bilingual personnel are available in Spanish, Portuguese and Khmer in each major clinical area except for the Metta Health Center where Khmer, Laotian, and Thai are

spoken. When staff is absent at smaller sites patients are scheduled by language and bilingual personnel are traded from site to site to meet the needs. The clinic supports staff participation in trainings. Bilingual health workers who interpret have had two levels of medical interpreter training: introductory and comprehensive. Lowell's records reflect these training levels and plans are often undertaken to upgrade skills. Staff is given "bonuses" upon completion of courses, and language training is
considered in annual reviews and salary increases.

CLAS Standards 1 and 6 – Patient Beliefs/Practices and Competent Language Assistance One trained bilingual staff member demonstrated a classic interpreter intervention while describing her interaction with an MD: "I hold my hand up and begin: 'Excuse me, the patient wants to explain something…it seems quite important to her.'"

2. Project Vida, El Paso, Texas. Motto – "To make a community whole."

History/Demographics/Patients Served (Population 700,000)
- 34% (300,000) lack health insurance
- 70,000 have incomes below 100% of the FPL*
- 80-100,000 undocumented individuals
- 9.8% Unemployment
- >100,000 eligible children not enrolled in Medicaid and S-CHIP
- Low rates of reimbursement for common procedures
- City-wide provider panels 70% Medicaid,
30% commercial

*FPL = Federal Poverty level

Best Practices **CLAS** Language Standards 4-7:
Project Vida's Staff are 95% Spanish speaking. The CLAS standards suggest that language needs are best served directly in the patient's first language and without intermediaries. Vida not only meets this standard, but likely exceeds it. Day-to-day operations are carried out in Spanish and English; some supervisors are monolingual Spanish-speaking.

CLAS Standards 4-7**:**
Defining health in its broadest sense Project Vida has learned that literacy, as a reflection of navigating life's systems and needs, must be addressed. Project Vida teaches fiscal literacy, fundamental language skills, ESL as well as health and social services literacy.

3. Harborview Medical Center (HMC), Seattle, Washington
Motto "...A comprehensive health care facility dedicated to the control, promotion and restoration of health**.**

History
Harborview Medical Center (HMC) began as a six-bed King County welfare hospital in a two-story South Seattle building in 1877. Today, HMC is a world-class trauma and 349-bed patient care center, as well as a teaching and research facility. The hospital serves all patients, regardless of their ability to pay.

Foreign-born populations (5-mile radius of HMC selected census tracts/neighborhoods
Region of Birth (Seattle's foreign born)

- Asia 55.8%
- Europe 16.0%
- Latin America 13.2%
- Africa 7.8%

Interpreter Service

Harborview Medical Center treats patients from over seventy different language groups with the help of interpreter services. In 1995 there were 35,000 interpreter hours. Last year there were over 106,000 hours of interpretation provided at HMC. Interpreter Services is primarily funded by the hospital's general funds. Federal Medicaid matching dollars account for a limited portion of the funding. In addition to serving the refugee population, Interpreter Services coordinates interpretation for all other non-English speaking patients and individuals requiring American Sign Language assistance at the Medical Center. HMC employs a staff of eight interpreters who cover the most frequently requested languages. When staff does not cover a language, HMC draws on its 66 contract interpreters for language services. The institution also has contracts with three language service agencies and one telephonic interpreting agency.

Qualifications and Training

P.L. 61-2004 charge number (4), now in order as the second most important component in the sequential process of certification, requires the Commission to recommend the level and type of education necessary to perform the job of: (A) a health [care] interpreter; and (B) a health care translator. In an age of increasing global awareness and technology, the linguistic aspect of needing trained and competent health care interpreters and translators lags behind by its lack of standardized training program to meet the need. There is a hodgepodge of interpreter training programs for bilingual individuals throughout the United States. Interpreting programs take on numerous training and educational approaches, show a variety of curricula, and there are no governmental regulations to drive the development of comprehensive training curricula for health care interpreters. Translation programs are available, but not enough to meet the demand, particularly in the area of health care translation needs.

To comply with the charge of setting forth qualifications and training, the Commission first deems it necessary to clarify that the fields of interpreting and translation are related, but that they require a different set of competencies. To delineate one specific set of qualifications and training for both health care interpreters and translators would be impossible, and the Commission has divided these two disciplines to show how each would meet certification requirements.

Understanding interpreter qualifications

Interpreting is a professional skill. Like all professionals, qualified interpreters must adhere to a set of standards of practice and a code of ethics, they must demonstrate their skills in the domain in which they are working, and they must receive appropriate training. Interpreters for the deaf have the advantage of having rigorous training, they have a national code of ethics and standards, and a certification program through the Registry of Interpreters for the Deaf (**RID**). The National Council on Interpreting in Health Care has recently produced and approved a National Code of Ethics for health care interpreters. Currently, however, only a handful of states require bilingual health care interpreters to undergo training. A majority of health care providers use individuals who adhere to no standards of practice or code of ethics, and no baseline proficiency level is required for employment, nor is the level of an individual's bilingual language skills assessed.

States that have made strides in outlining minimum skills for defining what would constitute qualified interpreters are Washington (the only state that currently offers state health care interpreting certification), Massachusetts, California, Oregon, and Minnesota. Below is a compendium of the minimum requirements for interpreters proposed by organizations from these states.

Language proficiency

Every interpreter needs to have a high level of competence in speaking or signing as well as a high level of comprehension in the two languages that are to be used.

Adherence to a Code of Ethics

A qualified interpreter must be aware of and adhere to ethical principles. The **NCIHC** National Code of Ethics is the culmination of several previously existing health care interpreter codes of ethics, in particular the *Bridging the Language Gap* from Minnesota, *Bridging the Gap: A Basic Training for*

Medical Interpreters from Washington, and the Massachusetts Medical Interpreters Association (**MMIA)** Code of Ethics.

Knowledge of interpreting

A qualified interpreter must have interpreter training that includes core interpreting skills, such as positioning of the interpreter, the use of the first person, transparency of the interpretation encounter, interpreter functions of conduit of information and cultural broker, and ethical protocols for advocacy.

Knowledge of health care terminology and health care systems

Language proficiency does not guarantee that an interpreter will know the terminology or have an understanding of the health care system that would allow him/her to interpret specialized vocabulary and understand its protocols.

Cultural Understanding

There is an interrelationship that exists between language and culture, and cultural beliefs may be vital to a full understanding of a patient's health care needs. A qualified interpreter needs to be aware of any cultural assumptions that may create a barrier to provider-patient communication.

Interpreters must have above average communication aural and oral (comprehension and speaking) skills with excellent knowledge of the languages used in the interpreting session. Interpreting demands a high degree of concentration and therefore most interpreters should plan on taking regular breaks to remain efficient, to maintain attention span and to implement the required memory skills needed to be a competent interpreter. A practice of rotating interpreters frequently during expanded interpreting sessions has been established in the American Sign Language interpreting community.

Understanding translator qualifications

The American Translators Association (**ATA)** is a national professional organization that sets and maintains standards for translation. Furthermore, it offers national certification for translators through a nationally recognized certification program that has been instrumental in establishing translation as a profession. The **ATA** has established a set of eligibility requirements to qualify candidates who wish to take the **ATA** certification exam. At the lowest level, individuals require proof of five years of experience working as a translator to be eligible to take the translator certification exam.

Writing Skills

Translators must have above average writing skills. They must comply with spelling, punctuation, and grammar rules, be able to write clearly, precisely and in the idiomatic usage of the language into which they are translating. Translators require the additional skills of research and use of specialized reference materials and current knowledge of written communication technology in translation and written communication. Translators must demonstrate a minimal level of competency to translate documents. The skill of translating is very different from the skill of interpreting; a person who is a competent interpreter may or may not be competent to translate (**HHS** Guidance).

Translators usually translate into their native language

Interpreters may have to engage in sight translation, which involves transferring the meaning of written text by oral delivery, reading in one language, and relaying the message orally in another language. In contrast, in translation the source (original) text may be in written or recorded format, but the target (translated) text must always be in written form. Whereas interpreters are expected to be equally fluent in at least two or more languages, and to be able to communicate effectively in all languages in which they interpret, it is more common for translators to translate from their second language into their first (native) language. Translation is commonly done from the second language into the first language, while interpreting is carried out in both directions. Whereas interpreters must develop highly competent memory skills, translators have more time to read over a text and more time to research terminology.

Proofreading and Editing Skills

When a translation is completed, it is recommended that the accuracy of the translation be ensured by having a second independent translator check, proofread and edit the work of the primary translator. Translators must assure consistency in the terminology and phrases used to translate. The permanent nature of written translation imposes additional responsibility to determine that the quality and accuracy of the translations permit meaningful access by **LEP** persons (**HHS** Guidance).

Comparative chart of interpreter skills and translator skills

Overlap occurs in the first three areas, but the last three areas require different competencies.

Interpreting skills	Translation skills
Language proficiency in two languages	Language proficiency in two languages
Guided by a Standards of Practice and Code of Ethics	Guided by a Standards of Practice and Code of Ethics
Bicultural (understanding of 2/more cultures)	Bicultural (understanding of 2/more cultures)
Knowledge of specialized terminology	Knowledge of specialized terminology with time to research unknown vocabulary
Excellent note-taking techniques	Excellent writing skills
Key skill is to be able to work bi-directionally, with equal expressive skills in both languages	Key skill is to write well. Professional translators almost always work in one direction, almost always translating into their native language.

Importance of understanding interpreter and translator skills

There are several translation programs available in higher education that provide adequate training for translators. The **ATA** offers certification for translators that is based on an individual's comprehension of two (or more) languages and tests the ability to translate accurately at a high level of skill. Likewise, the long-standing Registry of Interpreters for the Deaf (**RID**) has a certification program for American Sign Language (**ASL**) interpreters. Both of these professional organizations test the translator's or interpreter's language skills, but neither of these professional organizations tests specifically the knowledge of health care terminology and health care systems.

Research, training and educational opportunities are offered by health care facilities, Area Health Care Education Centers (**AHECs**), community agencies, state agencies, interpreting and translation agencies, community colleges, universities, distance learning courses, online training, and video-teleconferenced courses.

Due to the highly complex nature of interpreting and translation, both require that an individual possess skills and abilities specific to each discipline. In addition, in the field of health care, the interpreter or translator also needs to possess knowledge of health care terminology and health care systems. Although interpreting and translation are uniquely connected, each also requires a separate set of skills, the detailed qualifications and training that would be required of each need to be outlined separately.

Recommendations and criteria to be established for qualifications and training:

1. The Commission recommends writing a five-year Strategic Plan for implementation of a certificate program. Several activities may be carried out concurrently to assure the proper sequencing toward certification. The recommendations for **concurrent** activities are:

a) Establish a Committee on Qualifications for Health Care Interpreters that includes health care providers, specialists in the area of health care interpreting, and specialists in assessment to develop a plan for an initial assessment of interpreter qualifications for those who are currently working in the field. This Committee would work in sequential phases:

- Phase I will set up specific competencies that would be a minimal requirement to implementing certification for health care interpreters in the state of Indiana. During this phase the Committee will establish a time frame for an initial assessment of the basic competencies that would be required in Phase I and a registry of **"qualified health care interpreters"** in Indiana. The Commission recommends that this Committee adopt the **NCIHC**'s *Guide to Initial Assessment of Interpreter Qualifications* that includes Basic Language Skills, Knowledge and Understanding of a Code of Ethics, Interpreter Training Skills, Health Care Terminology and Health Care Systems, and Sight Translation of Simple Instructions.
- Phase II would be to establish the assessment components of these competencies and to make recommendations on how the assessments will be administered.
- Phase III will identify individuals, agencies, trainers and educators who would be qualified to carry out this initial assessment.
- Phase IV would initiate local and community-based capacity building and offer training of trainers throughout the state who could conduct the initial assessment.

Individuals who pass this initial assessment will hold the title of **"qualified interpreter"** until a certification program is implemented. The Commission realizes that this process may temporarily eliminate some interpreters who are currently working in the field. These individuals will have the opportunity to become qualified upon successful completion of training and/or educational programs that include the competencies in the initial assessment and upon passing the initial assessment. The availability of training programs and courses throughout the state is necessary to increase the likelihood of success for the Indiana certification program.

The competencies listed above are attainable. The most important, Basic Language Skills, is the most overlooked by current employers and needs to be earmarked as of the utmost importance not only for the professional development of the individual, but also to decrease interpreting errors, to improve communication between patient and provider, and to help to reduce health disparities.

Another task of this Committee will be to prepare individuals who are not currently working as health care interpreters. Some of the work will be done in Phase I. In Phase II a detailed outline will be drafted of specific interpreting skills and abilities needed to work as an interpreter, such as attention, analytical skills, memory, language transfer, and note-taking skills. Post-secondary education or its equivalent will be part of the training and/or educational process, as well as more in-depth assessment of health care terminology and health care systems. The most important aspect of these competencies will be additions to the assessment to include performance and integrative assessment tools. This Committee would:

- write the criteria for health care interpreter qualifications
- establish a recommended educational level or years of experience
- establish the core competencies
- establish the minimum training requirements that would be needed to prepare health care interpreters to meet the competencies

b) Establish a Committee on Health Care Translator Qualifications

Since the American Translators Association is the recognized professional body that offers certification for translators, the Commission does not endorse the establishment of a certified health care translator program. The Commission recognizes the need for trained health care translators, and this Committee would follow the same Phases as outlined in the Committee for Qualifications for Health Care Interpreters, but gear their work towards translators as follows:

- Phase I will set up specific competencies that would be minimal requirements to achieve the status of **"qualified health care translator."**
- Phase II will establish the assessment components of these competencies and make recommendations on how the assessments will be administered.
- Phase III will identify individuals, agencies, trainers or educators who would be qualified to carry out this initial assessment.
- Phase IV will initiate local and community-based capacity building and offer training of trainers throughout the state who could conduct the initial assessment.

The Committee will:

- Write the criteria for health care translator qualifications
- Establish a recommended educational level or years of experience
- Establish the core competencies
- Establish the minimum training requirements that would be needed to prepare health care translators to meet the competencies

c) Establish a Committee on Education and Training that will work in conjunction with the Committee on Qualifications by completing the following:

- compile a list of training and/or educational programs for interpreting and translation in the field of health care in the state of Indiana
- compile a list of training and/or educational programs for health care interpreting and translation in other states, including non face-to-face training courses
- interview potential trainers and educational entities that could provide training
- make recommendations of establishing partnership programs between trainers and educators with **AHECs** and health care providers for on site training and education
- prepare a cost analysis of training and/or educational programs

d) Establish a Committee on Language Proficiency Assessment.

Since testing basic language skills is a priority in the first step of interpreter readiness, the Commission recommends that this Committee complete the following tasks:

- compile a list of in-state agencies or educational entities that offer language proficiency testing
- compile a list of individuals in the state who are qualified language proficiency testers
- include a list of costs associated with language proficiency tests available
- survey agencies and educational institutions in the state that would consider partnership relationships for language proficiency testing
- survey educational institutions as potential testing sites
- compile a list of commercial or professional language proficiency tests and their associated costs

e) Establish a Committee on Assessment that will be responsible for surveying current assessment tools that could be adopted for the state of Indiana, or that will pursue the possibility of writing, piloting and validating a certification assessment tool that would reflect the needs of the populations served in Indiana.

2. The Commission recommends funds be appropriated for the development of an assessment tool. Unless legislative or private monies are made available for the development of an assessment tool for Indiana, working with other states will be the only option to move forward. There are assessment tools for certification of health care interpreters; however, they are not currently available. It should also be noted that the minimum period of time for writing, piloting, and validating an assessment tool that has been developed by other states has been three years.

3. During the interim period as steps are taken to identify "qualified health care interpreters," to assess "qualified health care translators" and to eventual certification, the Commission recommends that health care providers become educated about the qualifications of the health care interpreters and translators they are using. In particular, health care providers should ensure that interpreters and translators they use have received training so that they meet the minimal recommendations of **HHS**:

- A detailed knowledge of medical terminology
- Adherence to a Standards of Practice and Code of Ethics
- Cultural competency
- A knowledge of the operation of health care systems
- Advocacy
- Ability to work with physicians
- Professional development

Training in those areas, combined with a language assessment, would ensure the minimum skill level to provide competent interpreting and translating services in Indiana.

Regulatory Oversight

P.L. 61-2004 charge number (3), now in order as the third component in the sequential process of certification, requires the Commission to review and determine the proper level of regulation or oversight that Indiana should have over health care interpreters and health care translators practicing in Indiana.

The Commission reviewed and analyzed several regulatory models; however it concluded that any final decision about regulatory oversight would be premature at this time, given the amount of work that needs to be achieved to move into the implementation phase of certification. Therefore, the Commission recommends continuing the Commission for Health Care Interpreters and Translators until a permanent body is established to regulate certification of health care interpreters and assessment of qualified health care translators. The permanent regulatory body will require administrative support to carry out all functions, duties, and responsibilities assigned by law or rule to the regulatory body. The primary responsibility of the regulatory body should be to assure the competent delivery of health care interpreting and translation services to the Limited English Proficiency (**LEP**) population in Indiana. To fulfill this responsibility, the regulatory body should have the authority to:

- Assure that individuals have passed the required language assessment and testing requirements and have met all other education and training requirements necessary to be a certified health care interpreter or qualified health care translator.
- Enforce compliance with the standards of practice, code of ethics and any other statutes or rules regulating health care interpreters and translators.
- Maintain a registry or database of certified interpreters and qualified translators.

Although the Commission does not endorse or recommend any specific regulatory oversight model at this time because of the sequential process that needs to take place, the Commission has compiled a model for future consideration at the point that the certification program is implemented. The table below shows different options for regulatory oversight, administrative bodies, level of oversight, and criteria for eligibility. This model serves only as a future reference for purposes of helping with the Strategic Plan and acknowledgement of the minimum components of regulatory oversight.

Regulator/Organization	Administrator	Level of Oversight
Commission on Health Care Interpreters and Translators or other state entity	Commission staff or vendor	Compliance Certification (including setting standards) Registry/database Training Testing
State agency	State agency, community organization, or vendor	Compliance Certification (including setting standards) Registry/database Training Testing
Vendor (these entities would not qualify for regulatory oversight but could serve under the regulatory body as needed for contracting purposes)	Vendor	Interpreting skills Training program Training the Trainer Programs Language Assessment ID Card

Conclusions and Recommendations

The Commission has developed a plan for certification for health care interpreters. As stated, certification for translators exists at the national level, and the Commission therefore recommends a plan for establishing qualified health care translators. In both cases the Commission takes into consideration what currently exists for certification and the work in progress at the national level. Specific recommendations are listed within the subsections of the report, and included in the Executive Summary. The Commission includes here a shortened version of a global view of the sequencing process that is required for optimal outcomes and recommends the following:

1. The Commission recommends beginning public relations and educational efforts in Indiana to raise awareness of these issues to bring providers, interpreters and translators on board and to establish an identity system for the certification program. This should include the establishment of an identity system, monthly forums for health care organizations, interpreters and translators, and the community.

2. The Commission recommends adopting sequential steps to work towards health care interpreter certification and qualified health care translator. Included below is a visual model of the required sequencing for state health care interpreting certification. This model includes the permanent status of qualified health care translator recognizing that national certification for translators and American Sign Language interpreters is available and should be encouraged to acknowledge an advanced level of qualification for those achieving national certification. The arrows indicate that this is a bottom up model. It contains the minimum to maximum requirements that health care providers need to attain to comply with the standards set by the state of Indiana.

MINIMUM TO MAXIMUM REQUIRED SEQUENCE FOR HEALTH CARE INTERPRETER CERTIFICATION/QUALIFIED HEALTH CARE TRANSLATOR
BOTTOM UP

Sequence to follow towards Certification	Required assessments and training	
CERTIFICATION Fines/Sanctions Survey Mechanisms Certification (licensure) Certification Exam Certification Renewal	**MINIMUM REQUIREMENTS** State certification and ID for health care interpreters (recognition of certified ASL interpreters, but specialized training and qualifications required State ID for qualified translators (recognition of ATA certified translators, but specialized training and qualifications required) CEUS	REFER TO TIME CHART
INTERIM PHASE BEFORE CERTIFICATION "Qualified Health Care Interpreter" "Qualified Health Care Translator" Renewal (2 year period) Database/registry	**MINIMUM REQUIREMENTS** Successful completion of required competencies (initial assessment) CEUs	
MINIMUM LEVEL WITHOUT LEGISLATION Interpreting and translating skills Training program Language Assessment ID Card ↑	**MINIMUM LEVEL WITHOUT LEGISLATION** Successful completion of a 40-hour interpreter training program Oral language proficiency assessment (interpreters) and written proficiency assessment (translators) ↑	

3. The Commission reiterates that the state has embarked on a long-term process that is attainable and recommends adherence to the procedures for implementation of certification that have been successful at the national level. The following table gives a realistic and workable time frame to assure a valid certification program.

Time frame for Implementation of Certification for Health Care Interpreters and Qualified Health Care Translators

Entities	Year 1	Year 2	Year 3	Year 4	Year 5+
Commission on Health Care Interpreters and Translators	Write Strategic Plan; Monitor work and progress from established committees	Implement Strategic Plan working with various committees	Establish a permanent independent entity to serve as a Regulatory Body	Establishing rules for implementation and issuance of certification Implement Certification exam, certification survey mechanism, fines and sanctions	The Regulatory Body oversees certification programs, recommending policies and procedural changes as needed
Committee on Health Care Interpreter Qualifications	Develop and carry out initial assessment; Establish registry of "qualified health care interpreters"	Establish educational level and qualifications required for certified interpreters			
Committee on Health Care Translator Qualifications	Develop and carry out initial assessment; Establish registry of "qualified health care translators"	Establish educational level and qualifications required for qualified health care translators			
Committee on Training	Complete survey report of training and educational programs; Develop partnerships with potential training and educational programs	Establish minimal training or educational requirements for interpreter certification and qualified translator; Establish CEU requirements			
Committee on Assessment	Survey and recommend language assessment options; Survey current certification assessment tools; work with other states for possible adoption of certification exam	Completion of written certification in Spanish if no outside exam is available. Language demographics for need to write exam in other languages. Pilot exam	Pilot exam and test for validity and reliability	Implement certification exam	Continued assessment of certification exam.

4. The Commission recommends the need for its existence until certification has been implemented. It also recommends that future legislation allow for the Commission to be made up of those members who can attend and contribute to completing the goals of the Commission.

5. The Commission recommends the appointment of a permanent representative from a professional interpreting association serving deaf and hard of hearing persons or the Deaf and Hard of Hearing Services Board of Interpreter Standards to the Commission.

6. The Commission highly recommends that some form of permanent body of experts in the field of health care interpreting and translation be formed to review certification program policies and procedures and to implement changes as necessary.

7. The Commission recommends that the Committees on Health Care Interpreter Qualifications, Health Care Translator Qualifications, Training and Assessment be established as subcommittees of the Commission comprised of both Commission members and other subject matter experts as deemed necessary.

Appendix A: House Enrolled Act No. 1350

Enrolled Act, House Bill 1350

Second Regular Session 113th General Assembly (2004)

HOUSE ENROLLED ACT No. 1350

AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-18-2-62 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 62. (a) "Commission", for purposes of IC 16-19-6, refers to the commission for special institutions.

(b) "Commission", for purposes of IC 16-31, refers to the Indiana emergency medical services commission.

(c) "Commission", for purposes of IC 16-46-11.1, has the meaning set forth in IC 16-46-11.1-1.

SECTION 2. IC 16-18-2-161.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 161.5. "Health care interpreter", for purposes of IC 16-46-11.1, has the meaning set forth in IC 16-46-11.1-2.

SECTION 3. IC 16-18-2-163.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 163.5. "Health care translator", for purposes of IC 16-46-11.1, has the meaning set forth in IC 16-46-11.1-3.

SECTION 4. IC 16-46-11.1 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]:

Chapter 11.1. Commission on Health Care Interpreters and Translators

Sec. 1. For purposes of this chapter, "commission" refers to the commission on health care interpreters and translators established by section 4 of this chapter.

Sec. 2. For purposes of this chapter, "health care interpreter" means a professional interpreter who works primarily in the field of health care facilitating the oral communication among a:

(1) provider;

(2) patient; and

(3) patient's family.

Sec. 3. For purposes of this chapter, "health care translator" means a professional translator who:

(1) works primarily in the field of health care; and

(2) specializes in the translation of written medical documents from one

(1) language into another.

Sec. 4. The commission on health care interpreters and translators is established. The state department shall provide staff for the commission.

Sec. 5. (a) The commission consists of the following fifteen (15) members:

(1) One (1) member representing the state department.

(2) One (1) member representing local health departments.

(3) One (1) member representing the medical profession.

(4) One (1) member representing institutions of higher education in Indiana.

(5) Two (2) members representing patient advocacy groups.

(6) One (1) member representing community organizations.

(7) One (1) member representing interpreter professional associations.

(8) One (1) member representing translator professional associations.

(9) One (1) member representing hospitals.

(10) One (1) member representing the interagency state council on black and minority health.

(11) One (1) member representing the department of corrections who is nominated by the commissioner of the department of corrections

(12) One (1) member representing the department of education who is nominated by the state superintendent of public instruction.

(13) One (1) member representing the office of Medicaid policy and planning who is nominated by the director of the office of Medicaid policy and planning.

(14) The executive director of the health professions bureau or the executive director's designee.

The state health commissioner shall appoint the members of the commission designated by subdivisions (1) through (13). The appointments made under this subsection must be made in a manner to maintain cultural and language diversity.

(b) The state health commissioner shall designate:

(1) one (1) member as chairperson of the commission; and

(2) one (1) member as vice chairperson of the commission.

(c) Except for the member of the commission designated by subsection (a)(14), a member is appointed to a term of two (2) years or until a successor is appointed. A member may be reappointed to an unlimited number of terms.

(d) Except for the member of the commission designated by subsection (a)(14), if a member:

(1) resigns;

(2) dies; or

(3) is removed from the commission;

before the expiration of the member's term, the state health commissioner shall appoint a new member to serve for the remainder of the term.

(e) The expenses of the commission shall be paid from funds appropriated to the state department.

(f) Each member of the commission who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in

the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(g) The affirmative votes of a majority of the members appointed to the commission are required for the commission to take action on any measure.

(h) The commission shall meet quarterly or on the call of the chairperson.

Sec. 6. The commission shall do the following:

(1) Write bylaws concerning the operation of the commission.

(2) Define the terms "health care interpreter" and "health care translator".

(3) Review and determine the proper level of regulation or oversight that Indiana should have over health care interpreters and health care translators practicing in Indiana.

(4) Recommend the level and type of education necessary to perform the job of:

(A) a health interpreter; and

(B) a health care translator.

(5) Recommend standards that health care interpreters and health care translators should meet in order to practice in Indiana.

SECTION 5. [EFFECTIVE JULY 1, 2004] (a) The initial terms of office of the fourteen (14) individuals described IC 16-46-11.1-5(a)(1) through IC 16-46-11.1-5(a)(13), initially appointed to the commission on health care interpreters and translators under IC 16-46-11.1-5, as added by this act, are as follows:

(1) Seven (7) members for a term of one (1) year; and

(2) Seven (7) members for a term of two (2) years.

The state health commissioner shall designate the term of office of each individual initially appointed to the commission.

(b) This SECTION expires June 30, 2005.

SECTION 6. [EFFECTIVE JULY 1, 2004] (a) As used in this SECTION, "commission" refers to the commission on health care interpreters and translators established by IC 16-46-11.1-4, as added by this act.

(b) Not later than November 1, 2004, the commission shall report the commission's findings and recommendations determined under IC 16-46-11.1-6, as added by this act, to the health finance commission established by IC 2-5-23-3.

(c) This SECTION expires December 31, 2005.

Appendix B: Bylaws*

BYLAWS
of
THE INDIANA COMMISSION ON HEALTH CARE INTERPRETERS AND TRANSLATORS

ARTICLE I.
Name

The name of the commission shall be the Indiana Commission on Health Care Interpreters and Translators.

ARTICLE II.
Location

The principal office shall be at the Indiana State Department of Health, 2 North Meridian Street, Indianapolis, Indiana 46204, but may be changed to such place within the State of Indiana as the Commission shall determine.

ARTICLE III.
Purpose

The purpose of the Commission is to define the terms "health care interpreter" and "health care translator;" to review and determine the proper level of regulation or oversight that Indiana should have over health care interpreters and translators practicing in Indiana; to recommend the level and type of education necessary to perform the job of health care interpreter and/or translator; and to recommend standards that health care interpreters and translators should meet in order to practice in Indiana.

ARTICLE IV.
Commission Membership

Section 1.

The number of appointed members shall be fifteen (15).

Section 2.

The State Department of Health shall provide staff for the Commission.

Section 3.

The Commission shall consist of the following fifteen (15) appointed members:

(a) One (1) member representing the Indiana State Department of Health.

(b) One (1) member representing local health departments.

(c) One (1) member representing the medical profession.

(d) One (1) member representing institutions of higher education in Indiana.

(e) Two (2) members representing patient advocacy groups.

(f) One (1) member representing community organizations.

(g) One (1) member representing interpreter professional associations.

(h) One (1) member representing translator professional organizations.

(i) One (1) member representing hospitals.

(j) One (1) member representing the interagency state council on Black and Minority Health.

(k) One (1) member representing the Department of Corrections who is nominated by the Commissioner of the Department of Corrections.

(l) One (1) member representing the Department of Education who is nominated by the State Superintendent of Public Instruction.

(m) One (1) member representing the office of Medicaid Policy and Planning who is nominated by the Director of Medicaid Policy and Planning.

(n) The Executive Director of the Health Professions Bureau, or their designee.

Section 4.

The Indiana State Health Commissioner shall appoint the members of the Commission as designated in subdivisions (a) through (j).

Section 5.

The Chair shall be able to appoint ad hoc members to the Commission as he or she deems necessary. Said ad hoc members shall not possess voting privileges.

Section 6.

Except for the Executive Director of the Health Professions Bureau, or their designee, all members shall serve one or two year terms as appointed, or until a successor is appointed.

Section 7.

Individual members may be removed from the Commission as necessary based on the recommendation of the Commission Chair, and upon approval of the simple majority of the appointed members present.

Section 8.

If a member, except for the Executive Director of the Health Profession Bureau or their designee, resigns, dies or is removed from the Commission prior to the expiration of their appointment, the Indiana State Health Commissioner shall appoint a new member to serve the remainder of their term.

Section 9.

Members shall not receive any salary or other compensation for their services. Members who are State employees are entitled to reimbursement for travel expenses provided under IC 4-13-1-4, and other expenses incurred in connection with the member's duties as provided in state policies and procedures established by the Indiana Department of Administration and approved by the State Budget Agency.

Section 10.

State employees who serve on the Commission will further be expected to follow all federal ethics laws in exercising their roles and responsibilities as Commission Members. State participating agencies and their designated representatives shall review Executive Order 12731 of October 17, 1990 (or any corresponding provision of any future Executive Orders concerning "Principles of Ethical Conduct for Government officers and Employees.") Title 18 USCA, Section 205, as amended by P.L. 104-177 Federal Employee Representation Improvement Act of 1996 also should be reviewed.

Section 11.

Members may withdraw from the Commission by presenting to the Chair a written statement of resignation.

ARTICLE V.
Management of the Commission

Section 1.

The management of the business and affairs of the Commission shall be vested in the members. In addition to the powers and authority expressly conferred upon it by these Bylaws, the Commission may exercise such power and do all such lawful acts permitted by the State of Indiana. Such power shall include but not be limited to:

a) adopting policies and procedures for control of the affairs of the Commission; and

b) reviewing policies and procedures, laws, and regulations affecting the health care interpreter and translator professions;

Section 2.

The Chair shall reasonably ensure that a record of the proceedings of all meetings of the Commission is generated and maintained.

ARTICLE VI.
Meetings

Section 1.

The location of all meetings shall be the principal office of the Commission, unless otherwise stated in the Notice of Meeting or as the Commission may have previously determined.

Section 2.

The Commission shall meet quarterly, or on the Call of the Chair.

Section 3.

The affirmative votes of the simple majority of the appointed members present shall be required for the Commission to take any action on any measure.

ARTICLE VII.
Officers

Section 1.

The Indiana State Health Commissioner shall appoint a Chair who shall be responsible for the administration of the Commission within the framework of the policies and procedures, guidelines, and directives established by the members of the Commission.

Section 2.

The Indiana State Health Commissioner shall appoint a Vice-Chair who shall perform all duties incumbent upon the Chair when the Chair is not present or has not been elected, or at the request of the Chair. The Vice-Chair shall perform such other duties as this code of bylaws or Chair may prescribe.

ARTICLE VIII.
Amendment of Bylaws

The members of the Commission may make, alter, amend or repeal the bylaws subject to consideration and approval of a simple majority of the persons present then serving as members, if notice of the proposed alteration, amendment, addition, or repeal is contained in the notice which is delivered or mailed to each Member at least ten (10) days before such meeting.

ARTICLE IX.
Parliamentary Authority

All meetings of the Commission will be conducted in accordance with Robert's Rules of Order Revised in all cases to which they are applicable and in which they are not in conflict with these Bylaws.

ARTICLE X.
Construction and Terms

Section 1.

Should any conflict arise between the language and terms of these Bylaws and State Law, State Law shall govern.

Section 2.

Should any of the provisions of these Bylaws be held unenforceable for any reason, the remaining provisions of these Bylaws shall be unaffected by such holding.

I hereby certify that the above Bylaws were adopted by the members of the Indiana Commission on Health Care Interpreters and Translators under resolution at their meeting on the 26th day of August, 2004.

____

Chair

Members of the Indiana Commission on Health Care Interpreters and Translators

*The original version bearing signatures is on file at the Office of the State Health Commissioner at the Indiana State Department of Health.

Appendix C: Glossary of Health Care Terminology

Accredited college or university: Educational institutions or training programs with the recognition of meeting and maintaining standards that then qualify their graduates for professional practice. These may include community/state colleges, non-US degrees and /or training programs. (Adapted from the **NCIHC** 'accreditation' definition)

Ad hoc interpreter: An untrained person who is called upon to interpret, such as a family member, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual in a hospital waiting room who volunteers to interpret. Also called chance interpreter or lay interpreter. (**NCIHC**) Compare with **dual-role interpreters**.

American Sign Language (ASL): A complex visual-spatial language that is used by the deaf community in the United States and English-speaking parts of Canada. (**RID**)

Bicultural: A term describing a person who has some degree of proficiency in two cultures.

Bilingual: A term describing a person who is proficient in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter but does not assure the ability of the person to function as a competent or professional interpreter or translator. (Adapted from **NCIHC**)

Bilingual provider/employee: A person with proficiency in more than one language, enabling the person to provide services directly to non-English or limited-English proficient patients, but who is usually not trained as a professional interpreter. (Adapted from **NCIHC**) See **dual-role interpreter**s.

Biliterate: A term describing a person who has full degree of proficiency in two languages, along the dimensions of speaking/listening (or signing) and reading/writing.

Certificate: As used in this chapter, 'license' includes a license, certificate, registration, or permit. (As added by P.L. 152.1988, SEC. 1 (**IC** 25-1-9-3). See **license**.

Certification: A process by which an accredited governmental or professional organization attests to or certifies that an individual is qualified to provide a particular service. Certification calls for formal assessment, using an instrument that has been tested for validity and reliability, so that the certifying body can be confident that the individuals it certifies have the qualifications needed to do the job. Certificates of completion" given by training institutions to interpreters taking their courses, may not be equivalent to professional certification. (**CHIA**)

Certified interpreter: A professional interpreter who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. Interpreters who have had limited training or have taken a screening test administered by an employing health care, interpreter or referral agency are not considered certified. (**CHIA**)

Certified trainer: A professional health care interpreter/translator who holds credentials from a training to train program to train other health care interpreters or translators.

Certified translator: A professional translator who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. (Adapted from **HHS**)

Chain interpretation: An interpreting process in which two individuals attempting a conversation communicate through multiple interpreters, each of whom speak only one of the two languages required as well as a common third language. For example, Quechua may have to be interpreted into Spanish, which in turn is interpreted into English. (Adapted from **NCIHC**)

Code of Ethics: The principles of right and wrong that are accepted by members of the profession in the exercise of their professional duties. (Bancroft)

Commission (The): The Indiana Commission on Health Care Interpreters and Translators. (**IC** 16-46-11.1-1.)

Community interpreting: Interpreting that takes place in the course of communication in the local community among speakers of different languages. The community interpreter may or may not be a trained interpreter. (**NCIHC**)

Community/Liaison interpreting: Interpreting that takes place in the local community among speakers of different languages. (Adapted from **NCIHC**)

Consecutive interpreting: A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce the message after the speaker or signer pauses, in a specific social context. (**ASTM**) See **simultaneous interpreting.**

Continuing Education Units (CEUs): Values attached to educational and/or training programming to maintain professional development.

Cultural competency: A set of congruent/consistent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural situations. (**CCHCP**)

Cultural and Linguistically Appropriate Services in Health Care (CLAS) Standards: The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically services in health care. (**OMH**)

Dual-role interpreters: Health care staff members who can speak, read and/or write a second language other than English. They are not usually trained as professional interpreters. (**NCIHC**)

First-person interpreting: The promotion by the interpreter of direct communication between the principal parties in the interaction through the use of direct utterances of each of the speakers, as

though the interpreter were the voice of the person speaking, albeit in the language of the listener. For example, if the patient says, "My stomach hurts," the interpreter says (in the second language), "my stomach hurts," and not, "she says her stomach hurts." (**NCIHC**)

Health Care Access: The timely use of personal health services to achieve the best possible health outcomes. (Milliman)

Health care interpreter: A professional interpreter who works primarily in the field of health care facilitating the oral or visual/spatial communication between the provider and the patient and his or her family. (Adapted from **NCIHC**). See **health care interpreting.**

Health care interpreting/translating: Interpreting/translating that takes place in health care settings of any sort, including but not limited to doctor's offices, clinics, hospices, hospitals, home health visits, mental and health clinics. (Adapted from **NCIHC**)

Health care translator: A professional who specializes in the translation of written medical documents from one written language into another. (Adapted from **NCIHC**)

Health literacy: Health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions". (**HHS**)

Interpreter: A person who facilitates communication between two or more users of different oral or visual/spatial languages. (Adapted from **NCIHC**)

Interpreting:
(1) Noun: Referred to as Interpretation, the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account. (**ASTM**)
(2) Adjective: concerning or involved with interpreting.
(**NCIHC**)

Interpretation: While interpreting and interpretation have the same meaning in the context of oral/signed communication, the term interpreting is preferred, because it emphasizes process rather than product, and because the word interpretation has many uses outside the field of translation and interpreting. (**NCHIC**)

License: "license' refers to a license, certificate, registration, or permit." As added by P.L. 152.1988, SEC. 1 (Source: IC 25-1-9-3). See **certificate**.

Licensure: The process by which an individual obtains an official license or authorization to perform a particular job. A candidate for licensure may be required to achieve a passing score on a formal assessment of skills, but in some cases licensure only requires completion of a course of training, or a knowledge-based, rather than a skill-based, assessment. (**NCIHC**)

Limited English Proficiency (LEP): A legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter. (**ASTM**)

Limited English Proficient (LEP): A person who was not born in the United States or whose native language is a language other than English, whose difficulties in speaking, reading, writing, or understanding the English language may be sufficient to deny the individual the opportunity to participate fully in society. (Adapted from **NCIHC**)

Multi-lingual: A term describing a person who has some degree of proficiency in two or more languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter, but by itself does not insure the ability to interpret. (**NCIHC**) See **polyglot**.

National Health Law Program (NHeLP): A national public interest law firm that seeks to improve health care for American's working and unemployed poor, immigrants, minorities, the elderly, and people with disabilities. (**www. http://healthlaw.org**)

Non-English Proficient (NEP): A person who has no oral communication skills in English. (**CHIA**)

On-site interpreting: Interpreting done by an interpreter who is directly in the presence of the speakers. Also called face-to-face interpreting. (**NCIHC**)

Polyglot: A term describing a person who has some degree of proficiency in many languages. (**NCIHC**)

Professional interpreter: An individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to a code of professional ethics. (**NCIHC**)

Professional translator: An individual with appropriate training and experience who is able to translate with consistency and accuracy and who adheres to a code of professional ethics. (Adapted from **NCIHC**)

Proficiency: Thorough language and interpretation or translation competence derived from training and practice. (Adapted from **NCIHC**)

Provider: An entity (for example, an interpretation agency, consultant interpreter, or technological equipment company that contracts to deliver interpretation services or a component thereof. (Adapted from **ASTM**)

Relay interpreting: An interpretation process in which two or more interpreters take turns for long procedures and/or encounters in a health care setting. For example: sign language interpreters take turns interpreting after 30 minutes of continuous signing. (Adapted from **NCIHC**)

Remote interpreting: Interpreting provided by an interpreter who is not in the presence of the speakers, including but not limited to interpreting via telephone or video interpreting. (Adapted from **ASTM**)

Sight translation: Translation of a written document into spoken/signed language. **(ASTM)** An interpreter reads a document written in one language and interprets it into a second language. **(NCIHC)**

Sign(ed) language: Language of hand gestures and symbols used for communication with deaf and hearing-impaired people. **(NCIHC)**

Simultaneous interpreting: A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce in real time a speaker or signer's message while the speaker or signer continues to speak or sign in a specific social context. **(ASTM)** See **consecutive interpreting**.

Source language: The language of a speaker/signer who is being interpreted. The language of the text to be translated. **(ASTM)** See **target language**.

Standards of Practices: A set of rules and guidelines governing the conduct of members of a profession and aspects of practice of the profession. **(NCIHC)**

Summarizing: A limited interpretation that excludes all or most details focusing only on the principal points of the interpreted speech – not a full interpretation. **(NCIHC)** Summarizing speech is not considered acceptable in health care interpreting. **(CHIA)**

Target Language: The language of the person receiving interpretation. **(ASTM)** The language into which an interpreter is interpreting at any given moment. The language into which a text is to be translated. **(NCIHC)** See **source language**.

Telephone interpreting: Interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through a speakerphone or headsets. In health care settings, the principal parties, e.g., doctor and patient, are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone. **(NCIHC)** See **remote interpreting.**

Translation: The conversion of a written text from one language into a corresponding written text in a different language. In the language professions, the translation is distinguished from the interpretation as the former refers to the message produced in writing and the latter refers to the message produced orally or visually/spatially. (Adapted from **NCIHC)**

Translating: See **translation**.

Translator: A person who translates written texts, especially one who does so professionally. **(NCIHC)** See **translation, interpreter**.

Transparency/Transparent: The principle that everything that is said by any party in an interpreted conversation should be rendered in the other language, so that everything said can be heard and understood by everyone present. Whenever the interpreter has reason to enter into a conversation by speaking directly to either party in either language, the interpreter must subsequently interpret both

his/her own speech and that of the party spoken to, for the benefit of those present that do not understand the language used. Transparency is maintained when everything said by any party present, including the interpreter speaking for him/herself, is interpreted into a language that others present can understand. (**NCIHC**)

Video interpreting: Interpreting carried out remotely, using a video camera that enables an interpreter in a remote location to both see and hear the parties for whom s/he is interpreting via a TV monitor. (**NCIHC**) See **remote interpreting**.

Visual/Spatial Communication: All of the different visual forms of communication used by interpreters for the deaf including American Sign Language (**ASL**), and other sign language variance in other parts of the world, transliterated English "heard by word interpretation from English visual language", and tactile interpretation. **(RID)**

Appendix D: CLAS Standards

The Fourteen Cultural and Linguistically Appropriate Standards of Care

1. Health Care Organizations Should Ensure That Patients/Consumers Receive From All Staff Members Effective, Understandable, and Respectful Care That Is Provided in a Manner Compatible With Their Cultural Health Beliefs and Practices and Preferred Language

This standard constitutes the fundamental requirement on which all activities specified in the other CLAS standards are based. Its intent is to ensure that all patients/consumers receiving health care services experience culturally and linguistically competent encounters with an organization's staff. The standard is relevant not only to staff, who ultimately are responsible for the kinds of interactions they have with patients, but also to their organizations, which must provide the managers, policies, and systems that support the realities of culturally competent encounters.

Respectful care includes taking into consideration the values, preferences, and expressed needs of the patient/consumer. Understandable care involves communicating in the preferred language of patients/consumers and ensuring that they understand all clinical and administrative information. Effective care results in positive outcomes for patients/consumers, including satisfaction; appropriate preventive services, diagnosis, and treatment; adherence; and improved health status.

Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which patients/ consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options; using community workers as a check on the effectiveness of communication and care; encouraging patients/consumers to express their spiritual beliefs and cultural practices; and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise in cross-cultural issues.

Ways to operationalize this standard include implementing all the other CLAS standards. For example, in accordance with Standard 3, ensure that staff and other personnel receive cross-cultural education and training, and that their skills in providing culturally competent care are assessed through testing, direct observation, and monitoring of patient/consumer satisfaction with individual staff/personnel encounters. Assessment of staff and other personnel could also be done in the context of regular staff performance reviews or other evaluations that could be included in the organizational self-assessment called for in Standard 9. Health care organizations should provide patients/consumers with information regarding existing laws and policies prohibiting disrespectful or discriminatory treatment or marketing/enrollment practices.

2. Health Care Organizations Should Implement Strategies To Recruit, Retain, and Promote at All Levels of the Organization a Diverse Staff and Leadership That Are Representative of the Demographic Characteristics of the Service Area

The diversity of an organization's staff is a necessary, but not sufficient, condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual and individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all patients/consumers. Diverse staff is defined in the standard as being representative of the diverse demographic population of the service area and includes the leadership of the organization as well as its governing boards, clinicians, and administrative personnel.

Building staff that adequately mirrors the diversity of the patient/ consumer population should be based on continual assessment of staff demographics (collected as part of organizational self-assessment in accordance with Standard 9) as well as demographic data from the community maintained in accordance with Standard 11. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Staff diversity at all levels of an organization can play an important role in considering the needs of patients/consumers from various cultural and linguistic backgrounds in the decisions and structures of the organization. Examples of the types of staff members whose backgrounds should reflect the community's diversity include clinical staff such as doctors, nurses, and allied health professionals; support staff such as receptionists; administrative staff such as individuals in the billing department; clergy and lay volunteers; and high-level decision makers such as senior managers, corporate executives, and governing bodies such as boards of directors.

Acknowledging the practical difficulties in achieving full racial, ethnic, and cultural parity within the workforce, this standard emphasizes commitment and a good-faith effort rather than specific outcomes. It focuses not on numerical goals or quotas, but rather on the continuing efforts of an organization to design, implement, and evaluate strategies for recruiting and retaining a diverse staff as well as continual quality evaluation of improvements in this area. The goal of staff diversity should be incorporated into organizations' mission statements, strategic plans, and goals. Organizations should use proactive strategies, such as incentives, mentoring programs, and partnerships with local schools and employment programs, to build diverse workforce capacity. Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers.

3. Health Care Organizations Should Ensure That Staff at All Levels and Across All Disciplines Receive Ongoing Education and Training in Culturally and Linguistically Appropriate Service Delivery

Hiring a diverse staff does not automatically guarantee the provision of culturally competent care. Staff education and training are also crucial to ensuring CLAS delivery because all staff will interact with patients/consumers representing different countries of origin, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Health care organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME-or CEU- accredited education or other training in CLAS delivery, or arrange for such education and training to be made available to staff. This training should be based on sound educational (i.e., adult learning) principles, include pre- and post-training assessments, and be conducted by appropriately qualified individuals. Training objectives should be tailored for

relevance to the particular functions of the trainees and the needs of the specific populations served, and over time should include the following topics:

- Effects of differences in the cultures of staff and patients/consumers on clinical and other workforce encounters, including effects of the culture of American medicine and clinical training;
- Elements of effective communication among staff and patients/consumers of different cultures and different languages, including how to work with interpreters and telephone language services;
- Strategies and techniques for the resolution of racial, ethnic, or cultural conflicts between staff and patients/consumers;
- Health care organizations' written language access policies and procedures, including how to access interpreters and translated written materials;

The applicable provisions of:
(1) Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, 45 C.F.R. 80.1 et seq. (including Office for Civil Rights Guidance on Title VI of the Civil Rights Act of 1964, with respect to services for (LEP) individuals (65 FR 52762-52774, August 30, 2000).

- Health care organizations' complaint/grievance procedures;
- Effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative, and end-of-life care;
- Impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service utilization, quality of care, and health outcomes;
- Differences in the clinical management of preventable and chronic diseases and conditions indicated by differences in the race or ethnicity of patients/consumers; and
- Effects of cultural differences among patients/consumers and staff upon health outcomes, patient satisfaction, and clinical management of preventable and chronic diseases and conditions.

Organizations that conduct the trainings should involve community representatives in the development of CLAS education and training programs, in accordance with Standard 12.

4. Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation

Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. Title VI requires all entities receiving Federal financial assistance, including health care organizations, take steps to ensure that LEP persons have meaningful access to the health services that they provide. The key to providing meaningful access for LEP persons is to ensure effective communication between the entity and the LEP person. For complete details on compliance with these requirements, consult the HHS guidance

on Title VI with respect to services for (LEP) individuals (65 FR 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Language services, as described below, must be made available to each individual with limited English proficiency who seeks services, regardless of the size of the individual's language group in that community. Such an individual cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or nonclinical staff at a health care organization. (Patients needing services in American Sign Language would also be covered by this standard, although other Federal laws and regulations apply and should be consulted separately.)

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language. The competence and qualifications of individuals providing language services are discussed in Standard 6.

5. Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services

LEP individuals should be informed--in a language they can understand--that they have the right to free language services and that such services are readily available. At all points of contact, health care organizations should also distribute written notices with this information and post translated signage. Health care organizations should explicitly inquire about the preferred language of each patient/ consumer and record this information in all records. The preferred language of each patient/consumer is the language in which he or she feels most comfortable in a clinical or nonclinical encounter.

Some successful methods of informing patients/consumers about language assistance services include: (a) using language identification or "I speak * * *" cards; (b) posting and maintaining signs in regularly encountered languages at all points of entry; (c) creating uniform procedures for timely and effective telephone communication between staff and LEP persons; and (d) including statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

6. Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/ Consumer)

Accurate and effective communication between patients/consumers and clinicians is the most essential component of the health care encounter. Patients/consumers cannot fully utilize or negotiate other important services if they cannot communicate with the nonclinical staff of health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital

information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual--person for delivering language services they must assess and ensure the training and competency of individuals who deliver such services.

Bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter. Ideally, this should be verified by formal testing. Research has shown that individuals with exposure to a second language, even those raised in bilingual homes, frequently overestimate their ability to communicate in that language, and make errors that could affect complete and accurate communication and comprehension.

Prospective and working interpreters must demonstrate a similar level of bilingual proficiency. Health care organizations should verify the completion of, or arrange for, formal training in the techniques, ethics, and cross-cultural issues related to medical interpreting (a minimum of 40 hours is recommended by the National Council on Interpretation in Health Care). Interpreters must be assessed for their ability to convey information accurately in both languages before they are allowed to interpret in a health care setting.

In order to ensure complete, accurate, impartial, and confidential communication, family, friends or other individuals, should not be required, suggested, or used as interpreters. However, a patient/ consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the LEP person's confidentiality is violated. The health care organization's staff should suggest that a trained interpreter be present during the encounter to ensure accurate interpretation and should document the offer and declination in the LEP person's file. Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the patients/consumers.

7. Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area

An effective language assistance program ensures that written materials routinely provided in English to applicants, patients/ consumers, and the public are available in commonly encountered languages other than English. It is important to translate materials that are essential to patients/consumers accessing and making educated decisions about health care. Examples of relevant patient-related materials include applications, consent forms, and medical or treatment instructions; however, health care organizations should consult OCR guidance on Title VI for more information on what the Office considers to be "vital" documents that are particularly important to ensure translation (65 FR 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Commonly encountered languages are languages that are used by a significant number or percentage of the population in the service area. Consult the OCR guidance for guidelines regarding the LEP language groups for which translated written materials should be provided. Persons in language groups that do not fall within these guidelines should be notified of their right to receive oral translation of written materials.

Signage in commonly encountered languages should provide notices of a variety of patient rights, the availability of conflict and grievance resolution processes, and directions to facility services. Way-finding signage should identify or label the location of specific services (e.g., admissions, pediatrics, emergency room). Written notices about patient/consumer rights to receive language assistance services are discussed in Standard 5.

Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of patients/consumers. Organizations should provide notice of the availability of oral translation of written materials to LEP individuals who cannot read or who speak nonwritten languages. Materials in alternative formats should be developed for these individuals as well as for people with sensory, developmental, and/or cognitive impairments.

The obligation to provide meaningful access is not limited to written translations. Oral communication often is a necessary part of the exchange of information, and written materials should never be used as substitutes for oral interpreters. A health care organization that limits its language services to the provision of written materials may not be allowing LEP persons equal access to programs and services available to persons who speak English.

Organizations should develop policies and procedures to ensure development of quality non-English signage and patient-related materials that are appropriate for their target audiences. At a minimum, the translation process should include translation by a trained individual, back translation and/or review by target audience groups, and periodic updates.

It is important to note that in some circumstances verbatim translation may not accurately or appropriately convey the substance of what is contained in materials written in English. Additionally, health care organizations should be aware of and comply with existing State or local nondiscrimination laws that are not superceded by Federal requirements.

8. Health Care Organizations Should Develop, Implement, and Promote a Written Strategic Plan That Outlines Clear Goals, Policies, Operational Plans, and Management Accountability/Oversight Mechanisms To Provide Culturally and Linguistically Appropriate Services

Successful implementation of the CLAS standards depends on an organization's ability to target attention and resources on the needs of culturally diverse populations. The purpose of strategic planning is to help the organization define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services. It also allows the agency to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission.

The attainment of cultural competence depends on the willingness of the organization to learn and adapt values that are explicitly articulated in its guiding mission. A sound strategic plan for CLAS is integrally tied to the organization's mission, operating principles, and service focus. Accountability for CLAS activities must reside at the highest levels of leadership including the governing body of the organization. Without the strategic plan, the organization may be at a disadvantage to identify and prioritize patient/consumer service need priorities.

Designated personnel or departments should have authority to implement CLAS-specific activities as well as to monitor the responsiveness of the whole organization to the cultural and linguistic needs of patients/consumers.

Consistent with Standard 12, the strategic plan should be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected by the strategy.

And, consistent with Standards 9, 10, and 11, the results of data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

9. Health Care Organizations Should Conduct Initial and Ongoing Organizational Self-Assessments of CLAS-Related Activities and Are Encouraged To Integrate Cultural and Linguistic Competence-Related Measures Into Their Internal Audits, Performance Improvement Programs, Patient Satisfaction Assessments, and Outcomes-Based Evaluations

Ideally, these self-assessments should address all the activities called for in the 14 CLAS standards. Initial self-assessment, including an inventory of organizational policies, practices, and procedures, is a prerequisite to developing and implementing the strategic plan called for in Standard 8. Ongoing self-assessment is necessary to determine the degree to which the organization has made progress in implementing all the CLAS standards. The purpose of ongoing organizational self- assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment should focus on the capacities, strengths, and weaknesses of the organization in meeting the CLAS standards.

Integrating cultural and linguistic competence-related measures into existing quality improvement activities will also help institutionalize a focus on CLAS within the organization. Linking CLAS-related measures with routine quality and outcome efforts may help build the evidence base regarding the impact of CLAS interventions on access, patient satisfaction, quality, and clinical outcomes.

Patient/consumer and community surveys and other methods of obtaining input are important components of organizational quality improvement activities. But they should not constitute the only method of assessing quality with respect to CLAS. When used, such surveys should be culturally and linguistically appropriate.

10. Health Care Organizations Should Ensure That Data on the Individual Patient's/Consumer's Race, Ethnicity, and Spoken and Written Language Are Collected in Health Records, Integrated Into the Organization's Management Information Systems, and Periodically Updated

The purposes of collecting information on race, ethnicity, and language are to:

- Adequately identify population groups within a service area;
- Ensure appropriate monitoring of patient/consumer needs, utilization, quality of care, and outcome patterns;
- Prioritize allocation of organizational resources;
- Improve service planning to enhance access and coordination of care; and
- Assure that health care services are provided equitably.

Collection of data on self-identified race/ethnicity should adhere to the standard procedures and racial and ethnic categories specified in the Office of Management and Budget's most current policy directive and adapted in the U.S. Census 2000. To improve the accuracy and reliability of race and ethnic identifier data, health care organizations should adapt intake and registration procedures to facilitate patient/consumer self-identification and avoid use of observational/visual assessment methods whenever possible. Individuals should be allowed to indicate all racial and ethnic categories that apply. Health care organizations can enhance their information on subpopulation differences by collecting additional identifiers such as self-identified country of origin, which provides information relevant to patient/consumer care that is unobtainable from other identifiers.

The purpose of collecting information on language is to enable staff to identify the preferred mode of spoken and written communication that a patient/consumer is most comfortable using in a health care encounter. Language data also can help organizations develop language services that facilitate LEP patients/consumers receiving care in a timely manner. To improve the accuracy and reliability of language data, health care organizations should adapt procedures to document patient/consumer preferred spoken and written language. Written language refers to the patient/consumer preference for receiving health-related materials. Data collected on language should include dialects and American Sign Language.

For health encounters that involve or require the presence of a legal parent or guardian who does not speak English (e.g., when the patient/consumer is a minor or severely disabled), the management information system record and chart should document the language not only of the patient/consumer but also of the accompanying adult(s).

Health care organizations should collect data from patients/ consumers at the first point of contact using personnel who are trained to be culturally competent in the data collection process. Health care organizations should inform patients/consumers about the purposes (as stated above) of collecting data on race, ethnicity, and language, and should emphasize that such data are confidential and will not be used for discriminatory purposes. No patient/consumer should be required to provide race, ethnicity, or language information, nor be denied care or services if he or she chooses not to provide such information. All patient/consumer data should be maintained according to the highest standards of ethics, confidentiality, and privacy, and should not be used for discriminatory purposes.

11. Health Care Organizations Should Maintain a Current Demographic, Cultural, and Epidemiological Profile of the Community as Well as a Needs Assessment to Accurately Plan for and Implement Services That Respond to the Cultural and Linguistic Characteristics of the Service Area

The purpose of this standard is to ensure that health care organizations obtain a variety of baseline data and update the data regularly to better understand their communities, and to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Health care organizations should regularly use a variety of methods and information sources to maintain data on racial and ethnic groups in the service area. It is important that health care organizations go beyond their own data, such as marketing, enrollment, and termination figures, which may provide an incomplete portrait of the potential patient/consumer population, many of whom may not be aware of or use the organization's services. A more useful and in-depth approach would use data sources such as census figures and/or adjustments, voter registration data, school

enrollment profiles, county and State health status reports, and data from community agencies and organizations. Both quantitative and qualitative methods should be used to determine cultural factors related to patient/consumer needs, attitudes, behaviors, health practices, and concerns about using health care services as well as the surrounding community's resources, assets, and needs related to CLAS. Methods could include epidemiological and ethnographic profiles as well as focus groups, interviews, and surveys conducted in the appropriate languages spoken by the patient/consumer population. Health care organizations should not use the collected data for discriminatory purposes.

In accordance with Standard 12, health care organizations should involve the community in the design and implementation of the community profile and needs assessment.

12. Health Care Organizations Should Develop Participatory, Collaborative Partnerships With Communities and Utilize a Variety of Formal and Informal Mechanisms to Facilitate Community and Patient/ Consumer Involvement in Designing and Implementing CLAS--Related Activities

The culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care. As described below, this standard addresses two levels of consumer/patient and community involvement that are not token in nature, but involve working with the community in a mutual exchange of expertise that will help shape the direction and practices of the health care organization.

Patients/consumers and community representatives should be actively consulted and involved in a broad range of service design and delivery activities. In addition to providing input on the planning and implementation of CLAS activities, they should be solicited for input on broad organizational policies, evaluation mechanisms, marketing and communication strategies, staff training programs, and so forth. There are many formal and informal mechanisms available for this, including participation in governing boards, community advisory committees, ad hoc advisory groups, and community meetings as well as informal conversations, interviews, and focus groups.

Health care organizations should also collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served.

Related to Standard 11, health care organizations should involve relevant community groups and patients/consumers in the implementation of the community profile and needs assessment.

13. Health Care Organizations Should Ensure That Conflict and Grievance Resolution Processes Are Culturally and Linguistically Sensitive and Capable of Identifying, Preventing, and Resolving Cross-Cultural Conflicts or Complaints by Patients/Consumers

This standard requires health care organizations to anticipate and be responsive to the inevitable cross-cultural differences that arise between patients/consumers and the organization and its staff. Ideally, this responsiveness may be achieved by integrating cultural sensitivity and staff diversity into existing complaint and grievance procedures as well as into policies, programs, offices or committees charged with responsibility for patient relations, and legal or ethical issues. When these existing structures are inadequate, new approaches may need to be developed. Patients/consumers

who bring racial, cultural, religious, or linguistic differences to the health care setting are particularly vulnerable to experiencing situations where those differences are not accommodated or respected by the health care institution or its staff. These situations may range from differences related to informed consent and advanced directives, to difficulty in accessing services or denial of services, to outright discriminatory treatment. Health care organizations should ensure that all staff members are trained to recognize and prevent these potential conflicts, and that patients are informed about and have access to complaint and grievance procedures that cover all aspects of their interaction with the organization. In anticipation of patients/consumers who are not comfortable with expressing or acting on their own concerns, the organization should have informal and formal procedures such as focus groups, staff-peer observation, and medical record review to identify and address potential conflicts.

Among the steps health care organizations can take to fulfill this standard are: providing cultural competence training to staff who handle complaints and grievances or other legal or ethical conflict issues; providing notice in other languages about the right of each patient/consumer to file a complaint or grievance; providing the contact name and number of the individual responsible for disposition of a grievance; and offering ombudsperson services. Health care organizations should include oversight and monitoring of these culturally or linguistically related complaints/grievances as part of the overall quality assurance program for the institution.

14. Health Care Organizations Are Encouraged to Regularly Make Available to the Public Information About Their Progress and Successful Innovations in Implementing the CLAS Standards and To Provide Public Notice in Their Communities About the Availability of This Information

Sharing information with the public about a health care organization's efforts to implement the CLAS standards can serve many purposes. It is a way for the organization to communicate to communities and patients/consumers about its efforts and accomplishments in meeting the CLAS standards. It can help institutionalize the CLAS standards by prompting the organization to regularly focus on the extent to which it has implemented each standard. It also can be a mechanism for organizations to learn from each other about new ideas and successful approaches to implementing CLAS.

Health care organizations can exercise considerable latitude in both the information they make available and the means by which they report it to the public. For example, organizations can describe specific organizational changes or new programs that have been instituted in response to the standards, CLAS-related interventions or initiatives undertaken, and/or accomplishments made in meeting the needs of diverse populations. Organizations that wish to provide more in-depth information can report on the data collected about the populations and communities served in accordance with Standard 11 and the self-assessment results gathered from Standard 9. Organizations should not report scores or use data from self-assessment tools that have not been validated. However, as standard self-assessment instruments and performance measures are developed and validated, additional information gathered by using these tools could be made available to the public.

Health care organizations can use a variety of methods to communicate or report information about progress in implementing the CLAS standards, including publication of stand-alone documents focused specifically on cultural and linguistic competence or inclusion of CLAS components within existing organizational reports and documents. Other channels for sharing this information include

the organization's member publications; newsletters targeting the communities being served; presentations at conferences; newspaper articles; television, radio, and other broadcast media; and postings on Web sites. (Volume 65, Number 247) [Page 80865-80879])

Appendix E: Acronyms

AHECs	Area Health Care Education Centers
ASL	American Sign Language
BTG	*Bridging the Gap*
CEUs	Continuing Education Units
CLAS	Culturally and Linguistically Appropriate Services
IC	Indiana Code
LEP	Limited English Proficient(cy)

Appendix F: Professional Organizations and Agencies

AMA	The American Medical Association
ASTM	The American Society for Testing and Materials
ATA	The American Translators Association
CCHCP	The Cross Cultural Health Care Program
CHIA	The California Healthcare Interpreters Association
DHHS	The U.S. Department of Health and Human Services
ISDH	The Indiana State Department of Health
MMIA	The Massachusetts Medical Interpreters Association
NCIHC	The National Council on Interpreting in Health Care
NHeLP	The National Health Law Program
OMH	The Office of Minority Health
RID	The Registry of Interpreters for the Deaf

Appendix G: References

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